BMG | THE ENDOCRINE CLINIC

PEDIATRICS SELF ASSESSMENT

IDENTIFICATION:

Name: ______________________ Nickname: ______________
Date of birth: __________ Age: ______ years ______ months Sex: ☐ Male ☐ Female Race: __________
Child lives with: __________ Relationship: __________ Phone No.: __________
Mothers name: __________ Occupation: __________ Work Phone No.: __________
Fathers name: __________ Occupation: __________ Work Phone No.: __________

PAST MEDICAL HISTORY

1. Birth history:
   A. Pregnancy/delivery problem? __________
   B. Birth weight: __________ Length: __________
   C. Newborn problems? __________
2. Social: __________ grade in school Academic problems: __________
3. Development:

	Age		Age		Age
Roll over	______	Sit alone	______	Stand alone	______
Walk	______	Say words	______	Toilet train	______

4. Has your child ever had?

Measles	______ year	Rubella	______ year	Chickenpox	______ year
Mumps	______ year	Roseola	______ year	Scarlet Fever	______ year
Whooping Cough	______ year	Other ______	______ year		

5. Allergies:
   Medication: __________ Insect bite/stings: __________ Food: __________
6. Immunizations: ☐ Up to date ☐ Not up to date (Please explain on next line)
   ____
7. Serious injuries / other illnesses:
   ____
8. Hospitalizations / illnesses:

		Date	Physician	Reason
☐ surgery	☐ illness	______	______	______
☐ surgery	☐ illness	______	______	______
☐ surgery	☐ illness	______	______	______

9. Severe head trauma:
   ☐ YES ☐ NO if YES, explain: __________
10. Current / recent medications:

Medicine	Dose	Frequency
______	______	______
______	______	______
______	______	______

FAMILY MEDICAL HISTORY

11. Family Statistics:

	Age	Height	Weight	Age at Puberty/Menses	Health
Father:	______	______	______	______	______
Mother:	______	______	______	______	______
Sibling: male female	______	______	______	______	______
Sibling: male female	______	______	______	______	______
Sibling: male female	______	______	______	______	______

12. Family History Of: (please check YES if any of the following applies to a family member and list that relative

			Family member(s)
☐ YES	☐ NO	Birth defects / handicap	______
☐ YES	☐ NO	Delayed adolescence	______
☐ YES	☐ NO	Early puberty	______
☐ YES	☐ NO	Severe short stature	______
☐ YES	☐ NO	Infertility	______

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12. (cont'd) Family History Of: (please check YES if any of the following applies to a family member and list that relative

			Family member(s)
☐ YES	☐ NO	High cholesterol	______
☐ YES	☐ NO	Cancer	______
☐ YES	☐ NO	Diabetes	______
☐ YES	☐ NO	Dearness	______
☐ YES	☐ NO	Epilepsy or convulsions	______
☐ YES	☐ NO	Heart Attack or strokes (before 50)	______
☐ YES	☐ NO	Hypertension	______
☐ YES	☐ NO	Kidney problems	______
☐ YES	☐ NO	Mental retardation	______
☐ YES	☐ NO	Newborn deaths	______
☐ YES	☐ NO	Thyroid disease of goiter	______

Hereditary disease: ______ ______
Other: ______ ______

MEDICAL SYSTEM REVIEW

13. General Health:
☐ Poor health ☐ Weight loss ☐ Behavioral problems (explain) ______
☐ Other: ______

14. Eye Problems:
☐ Poor vision ☐ Corrective lenses ☐ Cross or turn out ☐ Other: ______

15. Ear Problems:
☐ Poor hearing ☐ Poor speech ☐ Repeated / Chronic ear infection
☐ Other: ______

16. Nose and Throat:
☐ Frequent runny nose ☐ Frequent Sore ☐ Frequent nosebleeds
☐ Other: ______

17. Skin Problems:
☐ Birthmarks ☐ Rashes / Hives ☐ Other: ______

18. Heart Problems:
☐ Heart Murmur ☐ Blue spells ☐ Listless / Tired
☐ Other: ______

19. Stomach and Intestinal Problems:
☐ Abdominal pain ☐ Jaundice ☐ Diarrhea
☐ Constipation ☐ Black / Bloody stool ☐ Worms
☐ Other: ______

20. Genital and Urinary Problems:
☐ Urinary infection ☐ Bed wetting ☐ Frequent / Burning urination
☐ Daytime wetting ☐ Menstrual problems ☐ Other: ______

21. Respiratory Problems:
☐ Frequent chest colds ☐ Shortness of breath ☐ Pneumonia
☐ Asthma / Hay fever diagnosed ☐ T.B. ☐ Other: ______

22. Bone, Joint, and Muscle Problems:
☐ Joint pain / swelling ☐ Weakness ☐ Broken bones
☐ Curvature of spine ☐ Other: ______

23. Central Nervous System Problems:
☐ Headaches ☐ Seizures ☐ Speech problems
☐ Delays in development ☐ Other: ______

22. Blood Problems:
☐ Easy bruising ☐ Sickle cell disease ☐ Bleeding problems
☐ Anemia ☐ Other: ______